		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038570

Facility Name: Shelbyville Manor

Address: Route 128 N. (Number) Shelbyville (City) 62565 (Zip Code)

County: Shelby

Telephone Number: (217) 774-2111 **Fax #** (217) 774-2209

IDPA ID Number: 37-1223745006

Date of Initial License for Current Owners: 09/01/80

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Ron Wilson
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Attached Independent Accountant's Report (Date)
(Print Name and Title) McGladrey & Pullen, LLP
(Firm Name & Address) 117 East Main, Suite 210, P.O. Box 1070 Galesburg, Illinois 61402
(Telephone) (309) 342-1175 Fax # (309) 342-7816

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	131	Skilled (SNF)	131	47,946	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	131	TOTALS	131	47,946	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,568	3,997	2,487	13,052	8
9	SNF/PED					9
10	ICF	13,135	11,668	0	24,803	10
11	ICF/DD					11
12	SC		0			12
13	DD 16 OR LESS					13
14	TOTALS	19,703	15,665	2,487	37,855	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.95%

D. How many bed-hold days during this year were paid by Public Aid? 6 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 12/01/92

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 08/25/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 13 and days of care provided 2,487

Medicare Intermediary Adminastar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	176,586	13,819	6,600	197,005		197,005		197,005			1
2	Food Purchase		163,557		163,557		163,557	(2,681)	160,876			2
3	Housekeeping	84,257	21,055	162	105,474		105,474		105,474			3
4	Laundry	55,109	16,610		71,719		71,719		71,719			4
5	Heat and Other Utilities			84,450	84,450		84,450	267	84,717			5
6	Maintenance	29,637	17,375	9,916	56,928		56,928	837	57,765			6
7	Other (specify):*											7
8	**TOTAL General Services**	345,589	232,416	101,128	679,133		679,133	(1,577)	677,556			8
	B. Health Care and Programs											
9	Medical Director			12,300	12,300		12,300		12,300			9
10	Nursing and Medical Records	1,314,191	120,911	2,740	1,437,842		1,437,842		1,437,842			10
10a	Therapy	105,965		10,508	116,473		116,473		116,473			10a
11	Activities	47,472	2,151	1,181	50,804		50,804	(195)	50,609			11
12	Social Services	38,758			38,758		38,758		38,758			12
13	Nurse Aide Training											13
14	Program Transportation			1,807	1,807	384	2,191		2,191			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,506,386	123,062	28,536	1,657,984	384	1,658,368	(195)	1,658,173			16
	C. General Administration											
17	Administrative	67,678			67,678		67,678	78,491	146,169			17
18	Directors Fees											18
19	Professional Services			161,393	161,393		161,393	(144,754)	16,639			19
20	Dues, Fees, Subscriptions & Promotions			38,177	38,177		38,177	(24,882)	13,295			20
21	Clerical & General Office Expenses	23,363	21,545	18,716	63,624		63,624	7,416	71,040			21
22	Employee Benefits & Payroll Taxes			285,419	285,419		285,419	12,711	298,130			22
23	Inservice Training & Education			5,770	5,770		5,770		5,770			23
24	Travel and Seminar			2,575	2,575		2,575	2,940	5,515			24
25	Other Admin. Staff Transportation			768	768	(384)	384	3,335	3,719			25
26	Insurance-Prop.Liab.Malpractice			45,561	45,561		45,561	189	45,750			26
27	Other (specify):* See Attached Sch VI			8,270	8,270		8,270	(8,270)				27
28	**TOTAL General Administration**	91,041	21,545	566,649	679,235	(384)	678,851	(72,824)	606,027			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,943,016	377,023	696,313	3,016,352		3,016,352	(74,596)	2,941,756			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Shelbyville Manor #0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			38,527	38,527		38,527	106,440	144,967			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			660	660		660	143,315	143,975			32
33	Real Estate Taxes			60,660	60,660		60,660	244	60,904			33
34	Rent-Facility & Grounds			319,902	319,902		319,902	(315,677)	4,225			34
35	Rent-Equipment & Vehicles			254	254		254	1,379	1,633			35
36	Other (specify):* **Amortization**							7,946	7,946			36
37	**TOTAL Ownership**			420,003	420,003		420,003	(56,353)	363,650			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			8,652	8,652		8,652		8,652			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,920	71,920		71,920		71,920			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			80,572	80,572		80,572		80,572			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,943,016	377,023	1,196,888	3,516,927		3,516,927	(130,949)	3,385,978			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,845)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(366)	30		9
10	Interest and Other Investment Income	(4,370)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(836)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,085)	27		24
25	Fund Raising, Advertising and Promotional	(23,352)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,542)	20		28
29	Other-Attach Schedule See Attached Schedule VII	(2,775)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,171)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense		31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(88,778)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (88,778)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (130,949)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Shelbyville Manor

ID# 0038570

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
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56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shelbyville Manor # 0038570 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,681)	0	0	0	0	0	0	0	0	0	0	(2,681)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,681)	0	0	0	0	0	0	0	0	0	0	(2,681)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(27,488)	0	0	0	0	0	0	0	0	0	(27,488)	19
20	Fees, Subscriptions & Promotions	(24,894)	0	0	0	0	0	0	0	0	0	0	(24,894)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(7,085)	0	0	0	0	0	0	0	0	0	0	(7,085)	27
28	**TOTAL General Administration**	(31,979)	(27,488)	0	0	0	0	0	0	0	0	0	(59,467)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(34,660)	(27,488)	0	0	0	0	0	0	0	0	0	(62,148)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Shelbyville Manor** **# 0038570** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(366)	0	0	0	0	0	0	0	0	0	0	(366)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,370)	0	0	0	0	0	0	0	0	0	0	(4,370)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(61,290)	0	0	0	0	0	0	0	0	0	(61,290)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(4,736)	(61,290)	0	0	0	0	0	0	0	0	0	(66,026)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(39,396)	(88,778)	0	0	0	0	0	0	0	0	0	(128,174)	45

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illini Manors, Inc.	100%	See Attached Schedule I		RFMS, Inc.	Galesburg	Admin. Svcs.
(100% owned by Don Fike)						
				L B Properties, Inc.	Galesburg	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	34	Facility Rental	319,902	L B Properties, Inc.	None	258,612	(61,290)	2
3	V				(78% owned by Don Fike)				3
4	V								4
5	V	19	Administrative Services	150,000	RFMS, Inc.	None	122,512	(27,488)	5
6	V				(100% owned by Don Fike)				6
7	V								7
8	V								8
9	V				See Attached Schedules III and IV				9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 469,902			$ 381,124	$ * (88,778)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Don Fike	President	Management	100.00	See Attached	>40	100.00	Salary	9,390	17-7	2
3					Schedule III			Benefits	770	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,160		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	Bank One, Springfield		x	Refinanced building mortgage	Varies Pd	05/09/96	2,624,827	2,124,255	04/01/11	6.6600	147,684	2
3					Quarterly							3
4	Interest Income Adjustment			From page 5, line 10							(4,370)	4
5												5
	Working Capital											
6												6
7	Miscellaneous Vendors		x	Miscellaneous operating							660	7
8	Home Office Allocation Adj.			See Attached Schedule III							1	8
9	TOTAL Facility Related						$ 2,624,827	$ 2,124,255			$ 143,975	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,624,827	$ 2,124,255			$ 143,975	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	56,460	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	58,560	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,100	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	58,560	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	60,660	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	51,973	8
	1996	54,603	9
	1997	54,741	10
	1998	56,418	11
	1999	58,560	12

Real estate tax accrual is based on estimated tax expense. The lessee, by terms of the lease agreement, is required to pay the applicable real estate taxes.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,041 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	6.87 Acres	1991	$ 20,000	1
2					2
3	TOTALS			$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90			1991	$ 991,000	$ 31,460	31.5	$ 31,460	$	$ 251,680	4
5	41			1992	1,138,566	36,145	31.5	36,145		289,160	5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot & Sidewalks			1991	45,000	3,000	15	3,000		24,000	9
10	Addition			1992	28,736	1,916	15	1,916		15,328	10
11	Paving			1993	2,417	133	10	242	109	1,775	11
12	Air Conditioning Unit			1994	1,943	173	7	275	102	1,943	12
13	Carpeting			1994	1,160	103	7	166	63	1,148	13
14	Cubicles and Curtains			1994	3,391	303	7	484	181	3,307	14
15	Cabinets			1994	10,042	896	7	1,435	539	9,806	15
16	Carpentry			1994	9,360	571	40	234	(337)	1,580	16
17	Painting			1994	5,585	341	40	140	(201)	945	17
18	Electrical			1994	8,578	525	40	214	(311)	1,427	18
19	Garage			1994	7,734	478	40	193	(285)	1,206	19
20	Floor Tile			1995	2,769	245	7	396	151	2,145	20
21	Flooring			1997	10,601	816	15	707	(109)	2,180	21
22	AC Condensor			1998	1,522	292	5	304	12	861	22
23	Flooring Tile			1998	3,390	593	7	484	(109)	1,371	23
24	Drywall & Fire Door			1999	17,500	1,263	40	438	(825)	621	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,289,294	$ 79,253		$ 78,233	$ (1,020)	$ 610,483	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 761,128	$ 47,778	$ 52,566	$ 4,788	5-15 yrs	$ 689,212	37
38	Current Year Purchases	3,674	735	243	(492)	5-8 yrs	243	38
39	Fully Depreciated Assets							39
40	Indirect Costs Allocated (See Attached Schedule III)		3,824	3,824				40
41	TOTALS	$ 764,802	$ 52,337	$ 56,633	$ 4,296		$ 689,455	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Patient Care	Ford Enc. Bus	1995	$ 42,500	$ 4,070	$ 6,071	$ 2,001	7 yrs	$ 30,861	42
43	Patient Care	Ford Bus	2000	48,365	9,673	4,030	(5,643)	4 yrs	4,030	43
44										44
45										45
46	TOTALS			$ 90,865	$ 13,743	$ 10,101	$ (3,642)		$ 34,891	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 3,164,961	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 145,333	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 144,967	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (366)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,334,829	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: L B Properties, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [x] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ See Attached			3
4	Additions				Schedule IV -			4
5					Related Party			5
6					Lease			6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE

All nurse aides have met training requirements.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 22,469	$ 108,350	1
2	Cash-Patient Deposits	1,789	1,789	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	662,927	1,079,710	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		291	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		387,450	8
9	Other(specify): See Attached Schedule VIII	1,238,647	1,238,647	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,925,832	$ 2,816,237	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		95,101	12
13	Land		20,000	13
14	Buildings, at Historical Cost		2,129,566	14
15	Leasehold Improvements, at Historical Cost	85,992	294,538	15
16	Equipment, at Historical Cost	280,001	1,465,078	16
17	Accumulated Depreciation (book methods)	(250,743)	(1,928,761)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Financing Costs		2,820	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 115,250	$ 2,078,342	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,041,082	$ 4,894,579	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,795	$ 162,562	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,789	1,789	28
29	Short-Term Notes Payable		240,301	29
30	Accrued Salaries Payable	173,790	250,374	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,288	3,288	31
32	Accrued Real Estate Taxes(Sch.IX-B)	58,560	63,720	32
33	Accrued Interest Payable		11,790	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivsion Payable			36
37	Other Accrued Liabilities		1,020,640	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 317,222	$ 1,754,464	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,124,255	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Resident Security Deposits			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,124,255	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 317,222	$ 3,878,719	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,723,860	$ 1,015,860	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,041,082	$ 4,894,579	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,342,766	1
2	Restatements (describe):		2
3	Year-end adjustments made subsequent to the filing of the		3
4	prior year's Medicaid cost report. (See Attached Schedule IX)	22,171	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,364,937	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	358,923	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 358,923	17
	B. Transfers (Itemize):		
18	Interdivision transfers		18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,723,860	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,803,639	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,803,639	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	60,169	6
7	Oxygen	2,297	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 62,466	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,768	13
14	Non-Patient Meals	1,845	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,613	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund Income	195	28
28a	Durable Medical Equipment	3,936	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,131	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,875,850	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	679,133	31
32	Health Care	1,657,984	32
33	General Administration	679,235	33
	B. Capital Expense		
34	Ownership	420,003	34
	C. Ancillary Expense		
35	Special Cost Centers	8,652	35
36	Provider Participation Fee	71,920	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,516,927	40
41	**Income before Income Taxes (line 30 minus line 40)****	358,923	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 358,923	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.** See Attached Schedule V

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	358	381	$ 7,611	$ 19.98	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	5,047	5,369	79,629	14.83	3
4	Licensed Practical Nurses	23,471	24,970	292,644	11.72	4
5	Nurse Aides & Orderlies	105,058	111,764	852,761	7.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,444	3,664	104,434	28.50	7
8	Rehab/Therapy Aides	66	66	1,531	23.20	8
9	Activity Director	1,738	1,849	16,180	8.75	9
10	Activity Assistants	3,700	3,936	31,292	7.95	10
11	Social Service Workers	3,036	3,230	38,758	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,523	23,960	176,586	7.37	15
16	Dishwashers					16
17	Maintenance Workers	2,026	2,155	29,637	13.75	17
18	Housekeepers	11,093	11,801	84,257	7.14	18
19	Laundry	8,548	9,094	55,109	6.06	19
20	Administrator	1,956	2,080	42,720	20.54	20
21	Assistant Administrator	2,040	2,170	24,958	11.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,956	2,080	23,363	11.23	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,029	2,158	18,886	8.75	31
32	Other Health C: Supervisors	6,946	7,389	62,660	8.48	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	205,035	218,116	$ 1,943,016 *	$ 8.91	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 6,600	1-3	35
36	Medical Director	***	12,300	9-3	36
37	Medical Records Consultant	***	1,420	10-3	37
38	Nurse Consultant	***		10-3	38
39	Pharmacist Consultant	***	1,320	10-3	39
40	Physical Therapy Consultant	***	10,508	10a-3	40
41	Occupational Therapy Consultant	***	0	10a-3	41
42	Respiratory Therapy Consultant	***		10a-3	42
43	Speech Therapy Consultant	***	0	10a-3	43
44	Activity Consultant	***		11-3	44
45	Social Service Consultant	***	0	12-3	45
46	Other(specify) Dental Consultant	***	0	10-3	46
47	Psychological Consultant	***		10-3	47
48	***=Monthly Fee Arrangement				48
49	TOTAL (lines 35 - 48)		$ 32,148		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Glenna Taylor	Administrator	None	42,720
Aaron Porter	Asst. Admin.	None	24,958
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,678

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
RFMS, Inc.	Administrative Services	150,000
McGladrey & Pullen, LLP	Accounting Services	11,393
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 161,393

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,145
Unemployment Compensation Insurance	26,985
FICA Taxes	144,543
Employee Health Insurance	67,330
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Plan Contributions	4,801
Other Employment Benefits	4,055
Employee Appreciation	560
Indirect Costs - See Attached Sch. III	12,711
TOTAL (agree to Schedule V, line 22, col.8)	$ 298,130

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,809
Health Care Worker Background Check	1,622
(Indicate # of checks performed 135)	
IHCA Dues	4,387
Subscriptions & Fees	1,187
Other Licenses	78
Advertising - Promotional	23,352
Advertising - Yellow Pages	1,542
Indirect Costs - See Attached Sch III	12
Less: Public Relations Expense	( )
Non-allowable advertising	(23,352)
Yellow page advertising	(1,542)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,295

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff use of personal vehicle on facility	
business and meals (under $250 per	565
travel voucher)	
Seminar Expense	2,010
Less out-of-state training	(1,395)
Indirect Costs - See Attached Sch. III	4,335
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,515

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Shelbyville Manor # 0038570 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2	None												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Manor # 0038570 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See page 21, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **6 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,820** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **71,920**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,845**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit not yet completed.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.